FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036194

Facility Name: O'Fallon Health Care

Address: 700 Weber Road (Number) O'Fallon (City) 62269 (Zip Code)

County: St. Clair

Telephone Number: 618-632-3511 **Fax #** 618-632-3053

IDPA ID Number: 37-1263590

Date of Initial License for Current Owners: May 31, 1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Cimarolli **Telephone Number:** 618-233-1001

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-2001 to 12-31-2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) J. Michael Greer

(Title) President

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) David Cimarolli, CPA

(Firm Name & Address) Creason-Edwards & Cimarolli, P.C.
4000 North Belt West

(Telephone) 618-233-1001 Fax # 618-233-6009

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	14,965	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	149	54,385	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,208	1,208	8
9	SNF/PED					9
10	ICF	21,019	9,987		31,006	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,019	9,987	1,208	32,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.23%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started June 1,1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date May 31, 1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,208

Medicare Intermediary AdminaStar Federal Louisville, KY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Dec 31, 2001 Fiscal Year: Dec 31, 2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	159,484	28,302	6,529	194,315		194,315		194,315			1
2	Food Purchase		150,714		150,714		150,714	(1,761)	148,953			2
3	Housekeeping	21,735	8,170	81,478	111,383		111,383		111,383			3
4	Laundry	13,835	8,412	54,319	76,566		76,566		76,566			4
5	Heat and Other Utilities			122,561	122,561		122,561		122,561			5
6	Maintenance	46,173	34,344	37,588	118,105		118,105		118,105			6
7	Other (specify):*											7
8	**TOTAL General Services**	241,227	229,942	302,475	773,644		773,644	(1,761)	771,883			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,067,838	66,256	59,755	1,193,849		1,193,849		1,193,849			10
10a	Therapy	41,807		168,642	210,449		210,449		210,449			10a
11	Activities	34,787	7,046	1,675	43,508		43,508		43,508			11
12	Social Services	39,810		9,408	49,218		49,218		49,218			12
13	Nurse Aide Training											13
14	Program Transportation			2,399	2,399		2,399		2,399			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,184,242	73,302	247,879	1,505,423		1,505,423		1,505,423			16
	C. General Administration											
17	Administrative	50,650	5,127	72,000	127,777	(1,317)	126,460	(49,006)	77,454			17
18	Directors Fees											18
19	Professional Services			31,174	31,174		31,174	1,142	32,316			19
20	Dues, Fees, Subscriptions & Promotions			31,617	31,617	1,317	32,934	(23,363)	9,571			20
21	Clerical & General Office Expenses	76,653	17,689	11,318	105,660		105,660	10,585	116,245			21
22	Employee Benefits & Payroll Taxes			186,481	186,481		186,481	2,080	188,561			22
23	Inservice Training & Education							766	766			23
24	Travel and Seminar			3,121	3,121		3,121		3,121			24
25	Other Admin. Staff Transportation			408	408		408		408			25
26	Insurance-Prop.Liab.Malpractice			90,471	90,471		90,471		90,471			26
27	Other (specify):* Bad Debt Expense			20,500	20,500	415	20,915		20,915			27
28	**TOTAL General Administration**	127,303	22,816	447,090	597,209	415	597,624	(57,796)	539,828			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,552,772	326,060	997,444	2,876,276	415	2,876,691	(59,557)	2,817,134			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number O'Fallon Health Care #0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			68,464	68,464		68,464	3,560	72,024			30
31	Amortization of Pre-Op. & Org.			134	134		134		134			31
32	Interest			67,677	67,677		67,677	(1,526)	66,151			32
33	Real Estate Taxes			32,462	32,462	(415)	32,047		32,047			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,283	11,283		11,283	(10,436)	847			35
36	Other (specify):*											36
37	**TOTAL Ownership**			180,020	180,020	(415)	179,605	(8,402)	171,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,973		108,973		108,973	(47,596)	61,377			39
40	Barber and Beauty Shops		7,814		7,814		7,814		7,814			40
41	Coffee and Gift Shops		5,261		5,261		5,261		5,261			41
42	Provider Participation Fee			81,577	81,577		81,577		81,577			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		122,048	81,577	203,625		203,625	(47,596)	156,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,552,772	448,108	1,259,041	3,259,921		3,259,921	(115,555)	3,144,366			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(288)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,526)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,473)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,336)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,889)	20		28
29	Other-Attach Schedule Dues(832)/Phar Rev(47596)	(48,428)	20/39		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (74,990)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(40,565)	17,19-23,	34
35	Other- Attach Schedule		30,34,35	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (40,565)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (115,555)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

O'Fallon Health Care

ID# 0036194

Report Period Beginning: 1-1-2001

Ending: 12-31-2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,761)	0	0	0	0	0	0	0	0	0	0	(1,761)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,761)	0	0	0	0	0	0	0	0	0	0	(1,761)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(49,006)	0	0	0	0	0	0	0	0	0	(49,006)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,142	0	0	0	0	0	0	0	0	0	1,142	19
20	Fees, Subscriptions & Promotions	(23,275)	744	0	0	0	0	0	0	0	0	0	(22,531)	20
21	Clerical & General Office Expenses	0	10,585	0	0	0	0	0	0	0	0	0	10,585	21
22	Employee Benefits & Payroll Taxes	0	2,080	0	0	0	0	0	0	0	0	0	2,080	22
23	Inservice Training & Education	0	766	0	0	0	0	0	0	0	0	0	766	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(23,275)	(33,689)	0	0	0	0	0	0	0	0	0	(56,964)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,036)	(33,689)	0	0	0	0	0	0	0	0	0	(58,725)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number O'Fallon Health Care # 0036194 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	3,560	0	0	0	0	0	0	0	0	0	3,560	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(10,436)	0	0	0	0	0	0	0	0	0	(10,436)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,526)	(6,876)	0	0	0	0	0	0	0	0	0	(8,402)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,562)	(40,565)	0	0	0	0	0	0	0	0	0	(67,127)	45

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael & Gail Greer	100%	O'Fallon Healthcare Center, Inc.	O'Fallon	Greer Management	O'Fallon	Management
Michael & Gail Greer	25%	Clinton Manor	New Baden			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	35	Computer Lease	$ 10,436	Greer Management		$	$ (10,436)	1
2	V	30	Depreciation		Greer Management		3,560	3,560	2
3	V	17	Administration	72,000	Greer Management		22,994	(49,006)	3
4	V	21	Clerical Wages		Greer Management		7,368	7,368	4
5	V	22	Payroll Taxes		Greer Management		2,080	2,080	5
6	V	19	Accounting		Greer Management		1,142	1,142	6
7	V	20	Dues & Subscriptions		Greer Management		744	744	7
8	V	23	Education		Greer Management		766	766	8
9	V	21	Office Expenses		Greer Management		3,217	3,217	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 82,436			$ 41,871	$ * (40,565)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Michael Greer	President	Working Officer	100.00				Working Offic	$ 0	17,1	1
2	Greer Management	President	Management					Mgmt Contract	72,000	17,3	2
3	Michael Greer	Greer Management	St. Ann's	50.00	48,000						3
4	Michael Greer	Greer Management	Clinton Manor	25.00	24,000						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 72,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 2-31-2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Greer Management
Street Address: 581 Country Side Lane
City / State / Zip Code: Trenton, IL 62293
Phone Number: (618-224-7715
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Management Fees	167,811	3	$ 21,973	$ 21,973	82,436	$ 10,794	1
2	17	Administrative	Management Fees	167,811	3	24,839	24,839	82,436	12,202	2
3	21	Clerical Wages	Management Fees	167,811	3	7,500	7,500	82,436	3,684	3
4	21	Clerical Wages	Management Fees	167,811	3	7,500	7,500	82,436	3,684	4
5	22	Payroll Taxes	Management Fees	167,811	3	4,236		82,436	2,081	5
6	19	Accounting	Management Fees	167,811	3	2,325		82,436	1,142	6
7	20	Dues & Subscriptions	Management Fees	167,811	3	1,514		82,436	744	7
8	23	Education	Management Fees	167,811	3	1,559		82,436	766	8
9	21	Office Supplies	Management Fees	167,811	3	3,932		82,436	1,932	9
10	21	Telephone	Management Fees	167,811	3	2,481		82,436	1,219	10
11	21	Postage	Management Fees	167,811	3	136		82,436	67	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 77,995	$ 61,812		$ 38,315	25

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Bank Of Illinois		X	Mortgage	$13,385.00	05-20-92	$ 1,600,000	$ 995,598	04-20-03	7.5000	$ 62,420	1
2	Michael Greer	X		Operating		01-01-92	295,000	250,000		8.0000		2
3	Buena Vista National Bank		X	Vehicle	$534.00	12-26-01	17,530	17,530	12-30-04	6.0000		3
4	First National Bank		X	Vehicle	$450.00	08-16-00	18,500	12,965	08-16-04	7.5000	1,199	4
5												5
	Working Capital											
6	First National Bank		X	S/T Working Cap Loan			55,000				1,845	6
7	First Bank		X	Line Of Credit			100,000				2,213	7
8												8
9	TOTAL Facility Related				$14,369.00		$ 2,086,030	$ 1,276,093			$ 67,677	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,086,030	$ 1,276,093			$ 67,677	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	32,047	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	32,047	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	32,047	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,047	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	30,754	8
1997	31,223	9
1998	31,144	10
1999	31,632	11
2000	32,047	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME O'Fallon Health Care COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0036194

CONTACT PERSON REGARDING THIS REPORT David Cimarolli

TELEPHONE 618-233-1001 FAX #: 618-2336009

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-32.0-200-063	700 Weber Dr.	$ 31,098.82	$ 31,098.82
2.	04-29.0-406-083	680 Weber Rd.	$ 948.30	$ 948.30
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,047.12	$ 32,047.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,003 B. General Construction Type: Exterior Brick Frame Wood/Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: -
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	493,476	1990	$ 50,000	1
2					2
3	TOTALS	493,476		$ 50,000	3

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	149		1990	1968	$ 1,070,706	$ 27,778	36	$ 27,778	$	$ 392,473	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage Building			1990	6,115		10			6,115	9
10	Building Improvements			1990	53,147	2,657	20	2,657		30,126	10
11	Painting			1991	29,153		7			29,153	11
12	Building Improvements			1991	18,498		8			18,498	12
13	Building Improvements			1991	12,908	645	20	645		7,008	13
14	Building Equipment			1991	15,936	797	20	797		7,127	14
15	Land Improvements			1992	17,531	1,753	10	1,753		15,939	15
16	Building Exterior			1992	20,000	1,000	20	1,000		9,087	16
17	New Roof			1992	20,700	1,035	20	1,035		9,578	17
18	Building Improvements			1993	20,648	1,032	20	1,032		8,436	18
19	Building Improvements			1994	4,418	442	10	442		3,503	19
20	Wall Covering			1995	16,310	1,631	10	1,631		10,614	20
21	Painting			1995	3,875	388	10	388		2,523	21
22	Signs			1996	4,537	648	7	648		3,300	22
23	Paved Lot			1997	7,182	718	10	718		3,171	23
24	Asphalt Improvement			1994	7,873	505	7	505		7,872	24
25	Building Improvements			1992	5,442	272	20	272		2,450	25
26	A/C Unit & Compressors			1999	23,022	882	39	882		2,030	26
27	Walk-In Cooler			1999	12,277	1,754	7	1,754		3,800	27
28	Ice Machine			1999	2,442	349	7	349		756	28
29	Sewer			2000	24,688	1,234	20	1,234		1,440	29
30	A/C Compressor			2000	23,213	595	39	595		942	30
31	Building Improvements			2001	75,825	1,406	39	1,406		1,406	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,496,446	$ 47,521		$ 47,521	$	$ 577,347	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 552,732	$ 13,870	$ 13,870	$		$ 515,280	71
72	Current Year Purchases	2,326	155	155			155	72
73	Fully Depreciated Assets							73
74	Leased Equip. (Greer Mgmt)	10,706	3,560	3,560			5,546	74
75	TOTALS	$ 565,764	$ 17,585	$ 17,585	$		$ 520,981	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1996 Subaru Wagon	1996	$ 16,420	$	$	$	3	$ 16,420	76
77	Facility	1999 Explorer	2001	17,758				5		77
78	Facility	Plymouth Van	2000	20,990	4,198	4,198		5	5,597	78
79	Facility	1990 Med Van	2000	13,633	2,727	2,727		5	4,317	79
80	TOTALS			$ 68,801	$ 6,925	$ 6,925	$		$ 26,334	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,181,011	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,031	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,124,662	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. 0
This amount was calculated by dividing the total amount to be amortized 0
by the length of the lease 0 .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,283 Description: Computer Equipment/Outside Storage
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$ 0.00	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				108,973		108,973	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 108,973		$ 108,973	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12-31-2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,316	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 55,060)	445,133		3
4	Supply Inventory (priced at)	22,424		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,265		6
7	Other Prepaid Expenses	3,893		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 505,031	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	1,000,000		14
15	Leasehold Improvements, at Historical Cost	425,740		15
16	Equipment, at Historical Cost	623,859		16
17	Accumulated Depreciation (book methods)	(1,048,410)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,051,189	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,556,220	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 141,328	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,430		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,084		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,047		32
33	Accrued Interest Payable	22,792		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 297,681	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,346		39
40	Mortgage Payable	995,598		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due Stockholder	250,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,277,944	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,575,625	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (19,405)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,556,220	$	48

***(See instructions.)**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,829	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,829	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(32,234)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (32,234)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (19,405)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,011,204	1
2	Discounts and Allowances for all Levels	(422)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,010,782	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	153,791	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 153,791	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,697	12
13	Barber and Beauty Care	8,007	13
14	Non-Patient Meals	288	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	47,596	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 61,588	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,526	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,526	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,227,687	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	773,644	31
32	Health Care	1,505,423	32
33	General Administration	597,209	33
	B. Capital Expense		
34	Ownership	180,020	34
	C. Ancillary Expense		
35	Special Cost Centers	122,048	35
36	Provider Participation Fee	81,577	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,259,921	40
41	**Income before Income Taxes (line 30 minus line 40)****	(32,234)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (32,234)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,405	2,476	$ 60,924	$ 24.61	1
2	Assistant Director of Nursing	2,000	2,088	46,344	22.20	2
3	Registered Nurses	20,910	21,104	331,344	15.70	3
4	Licensed Practical Nurses	1,240	2,083	29,988	14.40	4
5	Nurse Aides & Orderlies	53,808	56,392	562,049	9.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,412	3,738	41,806	11.18	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,088	2,173	20,828	9.58	9
10	Activity Assistants	2,153	2,179	13,959	6.41	10
11	Social Service Workers	3,491	3,720	39,809	10.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,952	2,088	29,489	14.12	14
15	Cook Helpers/Assistants	18,722	19,597	129,995	6.63	15
16	Dishwashers					16
17	Maintenance Workers	4,222	4,359	46,173	10.59	17
18	Housekeepers	2,961	3,128	21,735	6.95	18
19	Laundry	1,741	1,857	13,835	7.45	19
20	Administrator	1,960	2,088	50,650	24.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,809	7,177	76,653	10.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,498	3,626	37,192	10.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,372	139,873	$ 1,552,773 *	$ 11.10	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	146	$ 6,529	1	35
36	Medical Director	64	6,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Mo Fee	660	10	39
40	Physical Therapy Consultant	2,604	168,642	10	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	1,635	11	44
45	Social Service Consultant	41	1,675	12	45
46	Other(specify) Rehab Consultant	63	3,590	10	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,959	$ 188,731		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	2,289	55,505	10,3	52
53	TOTAL (lines 50 - 52)	2,289	$ 55,505		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Clindaniel	Adminstrator	0	$ 50,650
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,650

B. Administrative - Other

Description	Amount
Greer Management	$ 72,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 72,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Creason-Edwards & Associates	Accounting	$ 10,545
Giffin, Winning	Legal	6,910
St. Anne's Healthcare	Accounting	360
WDM Computer Service	Data Processing	5,095
Hepptech, Inc.	Computer Support	3,363
Home Pharmacy	Computer Support	1,400
Van Ostrand & Elvdge	Legal	2,842
Various	Computer Support	659
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 31,174

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,230
Unemployment Compensation Insurance	15,636
FICA Taxes	118,892
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Fringe Benefits/401k Employer Contr.	6,723
Payroll Taxes Greer Management	2,080
TOTAL (agree to Schedule V, line 22, col.8)	$ 188,561

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$ 0

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	7,795
Health Care Worker Background Check	
(Indicate # of checks performed 48)	576
Various Public Relations	19,336
Yellow Pages	3,889
Employee Drug Testing	1,000
Less: Public Relations Expense	(19,336)
Non-allowable advertising	( )
Yellow page advertising	(3,889)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,571

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
IHCA Convention	320
Professional Therapy Services, Inc.	750
Seminar Expense	
Various	2,051
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,121

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number O'Fallon Health Care # 0036194 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,290** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **81,577**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-** Has any meal income been offset against related costs? **-** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.